Addressing the Texas Health Care Crisis: Effective Use of Advanced Practice Registered Nurses

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ABSTRACT

Texas is experiencing an unprecedented health care crisis, including a shortage of primary care providers. The current site-based delegation practice model for advanced practice registered nurses (APRNs) restricts public access to qualified providers. APRNs are equipped to immediately address the crisis in Texas by providing accessible, affordable, high-quality care if they are permitted to practice to the full extent of their education and training. Texas APRN organizations are working with stakeholders to propose a new collaborative practice model during the 2013 legislative session. Using APRNs is projected to increase economic output to $26 billion and create 177,200 jobs by 2040.

Keywords: access to care, advanced practice registered nurse, APRN, independent prescriptive authority, primary care, scope of practice

The state of Texas is facing an unprecedented health care crisis. In 2008, more than 5.8 million Texans (nearly 25%) lacked health insurance, twice the national average. Indeed, Texas was the most uninsured state in the nation,[1] ranking last for access to health care, 47th in the active primary care physician supply ratio, and 46th in overall health care.[2] Texas has 214.2 physicians per capita, 41st in the nation.[3] Of 254 total Texas counties, 28 do not have a single practicing physician,[4] and 18 have only 1 physician.[5]

Current practice restrictions on advanced practice registered nurses (APRNs) limit their potential to play a critical role in addressing the primary care shortage. If permitted to practice within the full scope of their education and training, APRNs can address the health care provider crisis in Texas by providing accessible, affordable, high-quality care.

PROBLEM IDENTIFICATION

A national shortage of primary care providers (PCPs) began in 1994 when a surplus of 165,000 physicians was predicted. Between 1980 and 2005, medical school enrollment remained the same, despite a population increase of nearly 100 million. Medical colleges are now charged to increase enrollment by 30%, but the average time to train a physician is 10 years, and there is no immediate relief in sight.[4] In addition, the majority of medical students entering practice opt to pursue a specialty practice over primary care.

Medical schools are not keeping pace to produce enough PCPs to meet national demand.[6] Only 48% of available family medicine slots in 2010 were filled, as opposed to more than 90% of specialty slots, such as orthopedic, plastic, and vascular surgery. In 2009, only 9% of medical school graduates chose to pursue primary care.[7] With 50 million uninsured Americans (including 6 million Texans) set to receive health insurance in 2014 as a result of the Affordable Care Act, the nation's supply of primary care physicians will be quickly overwhelmed.[9]

Current predictions show the United States will need up to 200,000 additional physicians by 2020. Rural and underserved areas will suffer most.[4] Studies have shown that APRNs are more likely than physicians to show interest in serving these rural communities[10] and are also more likely to provide after-hours care. Further, the numbers of persons over 65 years old are estimated to reach 72.1 million by 2030, equating to 1 in every 5 Americans.[11] With an aging population comes increased incidence of chronic disease and disability.

APRNs are well situated to respond to these issues and integrate them into the delivery of primary care.[12]

The public awareness of the APRN role in the provider shortage has increased as press coverage has touted APRNs as accessible, affordable, and focused on patient-centered care and prevention.[13] Physicians in Texas have voiced concerns about APRNs in practice and purport that diagnosing and prescribing are rights to be granted solely to physicians.[14] Studies, however, have shown that patients have equal or better satisfaction scores with care from APRNs,[15,16] and APRNs with independent practice are sued two-thirds less often than those with delegated authority. APRNs provide quality care with no significant difference in patient outcomes,[17] number of prescriptions written, number of return visits, or referrals to other providers.[18]

Approximately 15,000 APRNs in Texas are qualified to provide care and help alleviate the health care provider shortage, yet they are unable to practice to the full extent of their education and training because regulation surrounding APRN practice in Texas is so restrictive.[19] As a result, the public is denied access to the care of qualified health providers.

BACKGROUND ON APRN PRACTICE IN TEXAS

The Texas Board of Nursing (BON) first began to regulate the education, eligibility, and practice requirements of APRNs in 1978. State laws were enacted in 1989 to increase access to care in rural clinics, and thus the need arose for independent prescriptive authority for APRNs. Stakeholders were able to negotiate delegated prescriptive authority to APRNs in medically underserved areas. The legislative trail that started then resulted in 1 of the most complex and confusing laws on prescriptive authority in the US.[20] As a result, APRNs have some autonomous elements of practice, such as diagnosing, which is delegated but carries no actual practice restrictions.

However, prescriptive authority is very complicated, with many variables and scenario-based rules that govern the ability to prescribe. Not only does Texas require each APRN to secure a collaborating agreement with a physician, but there are also many other limitations, which vary from practice to practice (Figure 1).

Simply lifting these complex restrictions would greatly increase Texans' access to care at no additional expense to the state.[21] The Texas Legislative Budget Board's January 2011 report to the 82nd Texas Legislature said that the state's "site-based, delegated model of prescriptive authority limits patient access to affordable, quality health care providers, particularly in rural and health professional shortage areas."[22]

In 35 states, diagnostic and prescriptive authority is granted by the BON. Sixteen of these states do not require a statutory relationship with a collaborating or delegating physician. Texas is 1 of only 4 states with site-based restrictions on prescriptive authority.[23] In 2003, the Texas Medical Association (TMA) offered a legislative compromise, granting APRNs the right to prescribe some (but not all) controlled substances. The prescriptions were still to be written under existing physician-delegated protocols. The price for this was agreement to a moratorium on all APRN initiatives related to autonomy expansion until 2009. APRNs agreed, viewing this as an opportunity to strategize and raise the necessary capital to plan a vigorous effort for independent prescriptive authority when the moratorium expired.[20]

In 2009, 2 bills that would have increased the scope of independent practice for Texas APRNs were introduced to the 82nd Texas Legislature. SB 1260 would have amended the Medical Practice Act to eliminate delegated prescriptive authority. SB 1339 would have allowed the BON to grant full diagnostic and prescriptive authority to qualified APRNs who completed a set number of hours of supervised practice.[24] The Federal Trade Commission (FTC) advised the 82nd Texas State Legislature that the passage of SB 1260 and SB 1339 would benefit Texas health care consumers by offering competition for quality, affordable health care.[16] The bills would give consumers more variety in the range of choices, as well as spark innovation in service delivery.

However, the political opposition to both bills was massive. TMA, which consists of nearly 50,000 licensed Texas physicians and medical students, expressed opposition to the expansion of APRN practice, and their opposition creates hesitancy for any politician tempted to step into the APRN camp. The TMA Political Action Committee (TEX-PAC) has an annual fund of over $1.5 million for lobbying efforts, 5 times more than the entire operating budget of the Coalition for Nurses in Advanced Practice